



DATE: _____

Personal Information for Adult and/or Guarantor

(Please print and complete all requested information on front and back of this form)

Name: _____ Name You Prefer _____

Address: _____ City: _____ State: _____ Zip: _____

Sex: M _____ F _____ Age _____ Birth Date _____

Status (Please Circle): Single Married Separated Divorced Partnered Widowed

Soc. Security No. _____ Name and Age of Children: _____ Age _____

_____ Age _____ Age _____ Age _____

____ Employed ____ Unemployed Employer _____ Occupation _____

Religious Affiliation _____ Congregation Name _____

List of Physicians you have seen in the last 24 months: _____

ANY KNOWN DRUG ALLERGIES: _____

Prescription and non-prescription medications you take _____

Amount of Alcohol (Beer, Wine, Mixed Drinks) you use each day _____ Week _____

Who Referred you? _____ May we contact them? ____ Yes ____ No

Previous counseling? ____ Yes ____ No If yes, When _____ With Whom _____

Concerns that bring you here _____

May we call you? ____ Home ____ Work ____ Other _____

Home Phone () _____ Work Phone () _____ Ext No. ____ Other _____

When is the best time to reach you? Time: _____ Days _____

In case of emergency is there another person we may contact? E-Mail Address: _____

Name _____ Relationship _____ Phone _____ Other _____

Please complete in full and sign back of form.

PRIMARY INSURANCE

Name of Policy Holder _____ Relationship to client _____

Policy Holder's Birth Date _____ Social Security No. _____

Employer Name and Address _____

Employer's phone () _____

Insurance Company Name and Address _____

Insurance Company phone () _____

Policy No. _____ Group No. _____

Secondary Insurance

Name of Policy Holder _____ Relationship to client _____

Policy Holder's Birth Date _____ Social Security No. _____

Employer Name and Address _____

Employer's phone () _____

Insurance Company Name and Address _____

Insurance Company phone () _____

Policy No. _____ Group No. _____

Responsible Party Other Than Client

Name and Address _____

Relationship _____ Employer _____

Work Phone () _____ Home Phone () _____

Rights and Responsibilities

The purpose of counseling is to help you clarify your goals and to achieve greater understanding and skills so you can reach your goals. Much of the success of counseling will depend on your willingness to participate fully in the process of developing goals that are significant to you. Your therapist's role will be to help you develop options for how you want to reach your goals. If you feel dissatisfied with any part of our work together, please let your therapist know immediately so your therapy will be as productive as possible. If you believe you have been treated unethically, by any counselor, and cannot resolve this issue with that person, you may contact the North Carolina Board of Licensed Professional Counselors at (919) 661-0820, North Carolina Marriage And Family Therapy Licensure Board (336) 794-3891, or North Carolina Social Work Certification and Licensure Board (800) 550-7009 or (336) 625-1679 for clarification of your rights or to lodge a complaint.

Authorization for Insurance & Consent for Services

I, the undersigned, have insurance coverage with _____ and assign directly to Presbyterian Counseling Center all medical benefits for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance company. I hereby authorize Presbyterian Counseling Center to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I hereby give my consent for treatment for myself and/or my child for services to be provided by Presbyterian Counseling Center. I understand that I may discontinue at any time. I have read the Presbyterian Counseling Center Information sheet and certify that the above information is correct.

Signature of Insured/Guardian/Responsible Party

Date